DOCUMENT RESUME

ED 086 909 CG 008 250

AUTHOR Rasche, Lois M.; And Others
TITLE Training Non-Counselor Professionals in the Application of Basic Counseling Principles.
PUB DATE Apr 73
NOTE 11p.; Paper presented at the American Personnel and Guidance Association Meeting, 15-19 April 1973, St. Louis, Missouri

EDRS PRICE MF-$0.65 HC-$3.29
DESCRIPTORS *Counseling Effectiveness; *Counselor Training; Empathy; *Helping Relationship; *Interpersonal Competence; Medical Students; Speeches; *Training

ABSTRACT

Immediately before and after taking a course on the physician-patient relationship, 102 sophomore medical students were measured on their preference for using understanding responses in a hypothetical patient interaction simulated by on objective test. Sixteen of these students were also rated on their use of understanding responses in an actual patient interview. A comparison of the pre- and post-measurement showed that students could identify an understanding response on a paper-and-pencil-test as well as make understanding responses in an actual interview situation to a significantly greater degree after having taken the course on the physician-patient relationship. This response type was compared to evaluative, reassuring, hostile and probing responses. All of these decreased as a function of the course, except the probing response which showed an increase in quality level. Implications for the training of students in a variety of service professions are discussed. (Author)

ED 086909

TRAINING NON - COUNSELOR PROFESSIONALS IN THE APPLICATION OF BASIC COUNSELING PRINCIPLES

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

Lois M. Rasche, Ph.D.
Southern Illinois University

Philip E. Veenhuis, M.D.
The Medical College of Wisconsin

Lewis Bernstein, Ph.D.
Veterans Administration Center, Wood, Wisconsin, and the Medical College of Wisconsin

A paper presented to the American Personnel and Guidance Association

St. Louis, 1973

CG 008 250

INTRODUCTION

Currently there has been a new emphasis on extending our counseling skills and techniques to paraprofessionals who can be trained to function as lay helpers in situations which are restricted to their training focus. Basic concepts such as empathy (Carkhuff, 1969), reflection of feelings (Rogers, 1951), confrontation, etc. seemingly can be taught to a variety of persons who do not have a broad background in counseling, psychotherapeutic theory or research (Ivey, 1968).

An area which has not been focused on in these attempts to communicate skills in human relations is that of the non-psychology professions concerned with intimate human contact such as medicine. This includes a wide variety of people - nurses, medical students, interns, residents, physicians and technicians.

Until recently the human aspect of medical assistance has been neglected in traditional medical school training. Interviews conducted by medical personnel are directed primarily to the medical aspects of the complaint, with little emphasis on understanding the emotional needs of the patient. Emphasis is on content, not feelings, although in a survey by Koos in 1955 on satisfaction with medical care, 64% of a randomly selected population criticized the present-day physicians for not being as warm as the family doctor of the past. Similarly, complaints of hospitalized groups centered around the depersonalization of the hospital patient by modern medicine.

Studies show that physicians will admit that they are deficient in their social-psychological skills (Menzel, Coleman, and Katz, 1959).

The importance of the socio-psychological skills of the physician is accentuated by estimates which suggest that 40-75% of all medical consultations are concerned with functional illnesses where the physicians cannot find organic sources of the problem (Bernstein & Dana, 1970).

It has been stated that the essentials of improvement for such functionally ill patients is determined primarily by the quality of the relationship between the health professional and the patient (Bennet, 1953). If this is accurate and indeed it makes a good deal of sense, we can assume that a physician is only able to help approximately fifty percent or fewer of such patients who seek his assistance, due to the functional nature of their problems and to his poorly developed interpersonal skills in these situations.

The result is that many patients remain unsatisfied and leave with poor impressions of the health professional which may influence their readiness to consult him on other problems. Others seek satisfaction from non-medical practitioners, even quacks who they claim tend to meet their needs for reassurance, consideration and communication--i.e., their psychological needs (Cobb, 1958; Koos, 1955).

Bernstein, Brophy, McCarthy and Roepe attempted to attack the problem of communication between the health professional and the patient in 1954 by offering a course on the Nurse-Patient relationship. This course consisted of discussions on how nurses tend to handle patient problems; the attitudes on the part of the nurses reflected by their handling of the problem; and how the patient might react to these behaviors. In this training project, Bernstein operated under the assumption that virtually every verbal response used in an interviewing situation falls into one of five categories: Evaluative, Hostile, Reassuring, Probing and Understanding, (Porter, 1950).

In the Evaluative response, the respondent makes an evaluation or judgment about the speaker's feelings, telling him directly or indirectly how he or she should feel.

In the Hostile response, the respondent depreciates or humiliates the person by an angry or judgmental attack, implying that the person is inappropriate in his feelings.

In the Reassuring response, the respondent tells the person everything will be all right, implying that the patient does not have a problem and does not need to feel as he does. This may stop the expression of the feeling but not the underlying conflict.

The Probing response is a questioning response which implies that if the listener just has enough information, he will be able to help him.

The Understanding response consists of trying to understand the person's point of view and communicating that understanding to the person. The advantage of the understanding response is that it enables the person speaking to feel more free to explore the situation and his own response to it. He will tend to feel safe and accepted, will probably feel more receptive to the listener and tend to be more cooperative with him. In addition, the respondent using the understanding response has avoided being defensive, judgmental or insensitive to the person's needs, (Bernstein & Dana, 1970).

On the basis of this categorization of responding, Bernstein et.al. constructed the Nurse-Patient Situation Test which consists of 35 Nurse-Patient incidents with five possible nurse responses to the patient's statement, each corresponding to these five response categories. In the course, the "Understanding" response was emphasized while the other four were deemphasized. This group of nurses was compared with a control group which was simply given pre- and post-tests with no intervening instruction.

The experimental group showed significant increases in Understanding response choices and significant decreases in three of the four other responses as a function of the course, as compared to controls. The hostile responses did not decrease; however, their frequency was very low to begin with.

This approach was later extended to medical students. A course was offered to sophomore medical students at the Medical College of Wisconsin consisting of a four hour weekly class. Students were grouped into classes of 8 or 9, each of which was taught be either a psychologist or psychiatrist.

1. The first hour of each class was spent by the students in interviewing patients on non-psychiatric wards in an attempt to learn to recognize emotional components of illness. Psychiatric wards were not included to emphasize that emotional problems accompany all illnesses.

2. During the second hour the students discussed their interviews with the other members of the group.

3. The third hour was used for a demonstration interview by the instructor. This was usually done with a patient who had presented a problem for one of the students.

4. The fourth hour was used for discussion of the demonstration interview and general concepts of interviewing and personality dynamics.

Halfway through this course the students continued their activities in a different hospital setting with a different instructor. Thus they had these interviewing experiences in both public and private hospitals with both a psychologist and psychiatrist as an instructor.

Bernstein et. al. compared this population to a control group of freshman students on their ability to accept the patient as a person as measured by the Test of Clinical Judgment. This test required them to evaluate how normal certain statements by others were and served as a measure of criticalness. While both groups were the same on their initial degree of acceptance of others--(fairly rigid about what they defined as normal), the experimental group showed significantly more acceptance of others as a function of their coursework on interviewing, (Bernstein, Headlee & Jackson, 1970).

These studies indicated that nurses were able to identify and choose Understanding responses as the preferred response on an objective measure, and that medical students became more accepting of patients as a function of this interviewing course. However, it had not been demonstrated that medical personnel, in addition to identifying the Understanding response on a paper and pencil measure, could actually make Understanding responses in an interview situation.

The present study attempted to determine whether medical students actually could learn to give Understanding responses in an interview with a patient. The same basic 4-hour course structure was used in the present study.

METHOD

102 sophomore medical students at the Medical College of Wisconsin were administered the revised form of the Nurse-Patient Situation Test for physicians before and after taking a course on the physician-patient relationship. Students were asked to respond to this test as if they were interacting with the patient directly.

The following statement made by a 46-year-old male is an example of a test item:

"Well, this new man came into the company. He's a big show, has all the answers. Thinks he's going places. But, by God, he doesn't know me. I'll get ahead of him if I have a stroke trying."

Several of the response choices for this item which correspond to the five categories of response are:

a. I don't care how you run your business life, but I wish you'd quit trying to be such a big shot here on the ward. (hostile)

b. It's a fine thing to try to get ahead but do you think that by starting out with such an attitude toward him you're going at it right? (evaluative)

c. You're really determined that he won't beat you out. (understanding)

The large group of students was broken down into small groups of approximately 8-10 each, which met 4 hours weekly for 16 weeks for a course on Interviewing in the Physician-Patient Relationship. In addition they were asked to read Interviewing and the Health Professions (Bernstein & Dana,1970) as a textbook.

The students in two such groups of 8 each were asked to tape record their first interview with a medical patient, prior to any formal learning experience and their last interview at the end of the course. The students were told to simply try to understand how illness can affect other aspects of a patients's life, i.e. to deemphasize the emphasis on the medical history of the patient and to focus on how the patient experienced his hospitalization. This was an attempt to hel the students learn to understand the person better.

With the exception of playing and discussing a tape recorded interview made by one student each week during the second hour of the class, the course progressed as described in the Bernstein, Headlee and Jackson study, 1970. The Understanding response became the target of training while the Evaluative, Reassuring, Probing and Hostile responses were deemphasized in the course, as well as in the textbook.

Pre- and post- tapes were coded by the experimenters before given to the raters so that they could not differentiate them. Five raters who had either taught other sections of the course or had familiarity with the concepts taught in the course rated the tape. In addition to this experience, the raters were trained by:

a) listening to a practice tape together and discussing each response before rating;

b) Listening to a second sample tape, rating it independently and then discussing it.

All experimental tapes were than rated independently by each rater. All raters listened to 50 responses by the student on each tape. In most cases, this represented the entire tape or about 30 minutes of an interview. Three types of ratings were made:

1. Each student response was rated as being in one of five categories-- Evaluative, Hostile, Reassuring, Probing or Understanding.

2. The probing responses were rated on quality levels because of the degree of variation possible in that category, i.e. interviewers could ask an irrelevant question or a facilitative questionwhich helped communicate understanding and prompted self-disclosure.

3. Each taped interview was also rated on overall quality on a scale of 1--5, based on the raters' general impression.

This impression, of course, was related to number of Understanding responses, quality of probing responses, etc., but in an intuitive way, not quantitative.

Hypotheses

1. It was hypothesized that students would show a significant increase in Understanding response choices from pre-to post-testing on the Nurse-Patient Situation Test, as well as increase in their use of Understanding responses in the actual interview situation.

2. It was also hypothesized that their choices of the other four response types would decrease from pre-to post-testing on the objective test and in the interview situation.

RESULTS

A t-test comparison of the pre-and post-test scores on the revised Nurse-Patient Situation Test showed a significant increase in Understanding response choices on the test from pre-to post-measurements ($t=18.94$, $p<.001$). All other responses showed significant decreases from pre to post testing, as predicted. (See Table 1).

Because the number of student responses varied depending upon the length of the interview and the level of verbal activity of both the student and the patient, the frequency of responses within each category was converted into a percentage of the total responses for that interview. The average percentage of responses in each category for all raters was used as the dependent measure.

In the analysis, t tests of the difference scores were used for these pre-post comparisons. Because the alpha level tends to become inflated when multiple t tests are used, the level of significance acceptable for these findings was set at .01.

As hypothesized, the percentage of Understanding responses increased significantly from pre-training to posttraining interviews ($t=3.84$, $p<.005$). With the exception of two Ss who decreased in percent of understanding responses slightly (by two responses) and one who increased by one response, all Ss at least tripled their percentage and in some cases exceeded the pre-training response level by more than 20 times.

The second hypothesis stated that the remaining four response categories would decrease as a function of training but the relative amount of decrease was not specified.

The percentage of Evaluative responses decreased significantly from pre-to post-interviews as was expected ($t=2.78$, $p<.01$) level. Under the level of significance restrictions for multiple t tests, the remaining three response types did not reach significance, however they did increase. Reassuring, Hostile, and Probing responses did not show significant decreases as a function of training: Reassuring, $t=2.19$; $p<.025$; Hostile: $t=1.94$, $p<.05$; Probing: $t=.05$, $p>.05$ (See Table 2).

Interrater reliability on the five categorizations was measured by an Analysis of Variance technique for reliability. The estimates of reliability were: Understanding .95, Probing .96, Hostile .91, Evaluative .94, Reassuring .88. These estimates were obtained by use of a procedure wherein the frame of reference of each judge is removed from the analysis, (Winer, 1962).

Apparently the increase in the Understanding response resulted primarily from the decrease in evaluative responses, although all the response types decreased somewhat. The probing response showed the least significant frequency change. However, when this was broken down by raters into quality levels--facilitative, non-facilitative and neutral, significant pre-post differences emerged. The quality of the probing responses increased significantly as a function of training. All but one S at least tripled their frequency of good quality probing responses, ($P+$: $t=4.05$, $p < .001$). The neutral responses also increased significantly by (P_n: $t=2.98$, $p < .01$). The non-facilitative responses decreased significantly. ($P-$: $t=4.06$, $p < .001$).

The overall quality rating of the interview on a 1--5 scale with 1 representing a poor interview and 5 a very good interview also showed a significant increase in general quality from pre- to post-testing ($t=4.83$, $p < .001$). The average pre-training score for overall quality was 1.18 while the average post-training score for overall quality was 2.73.

DISCUSSION:

The significant increases in Understanding response choices from pre- to post-testing on the Nurse-Patient Situation Test indicates that students were able to differentiate between Understanding responses and non-facilitative responses on an objective situational test. The significant increases in Understanding responses from pre to post interviews suggest that the students could also produce these Understanding responses in an interview situation. Furthermore, the increase in quality level of the Probing response after training indicates that the students were able to grasp a general concept of facilitative responding, not simply learn to make an "understanding" statement.

In retrospect, it seems logical that the Probing (questioning) response might remain strong, since questioning is one way of attempting to understand. In fact, the Probing response was the most frequently occuring response type in both pre and post interviews.

Since Hostile responses were very low in frequency, it is understandable that significant differences would be difficult to obtain although the actual frequency percentage decreased from 9.8 to 1.8 percent responses. Bernstein et al., 1954, also did not find significant decreases in hostile responses in their training of nurses.

It is not clear why the Reassuring response did not reach significance. However, the mean percent frequency drops from 14.8 to 6.1 from pre-to post-training and almost reaches significance acceptable for the multiple t-test ($P=<.025$), suggesting considerable decreases as compared to the minimal differences between pre and post probing and hostile responses. Trainers of counselors would probably agree that there is a strong tendency for a naive interviewer to reassure the person in distress. Possibly that response set is a difficult one to break in a short period of time.

Evaluative or advice giving responses showed the most decrease after training, perhaps because the emphasis was on understanding, not "doing or telling."

In summary, this study indicates that a group of sophomore medical students were able to master this concept of understanding both by identifying it as the most appropriate response type and by using it in their interviewing. Such interviews were rated by trained raters as better interviews than those where fewer Understanding responses occurred. In addition they were able to improve on the quality of their questions, making them more relevant and facilitating.

The Understanding response is not unique, nor are the 5 response types magical. The importance of this study is in the achievement of reorienting medical students to take an approach of looking at the patient as a person with feelings about his experiences, not simply as a body to be attended to--an answer to the expressed patient needs for more personal warmth from their physicians.

The core of this approach appears to be the simplification of complex aspects of interpersonal communication, uncomplicated terminology, and a simple experiential teaching method. Clearly there is a demand for this sort of training in the medical profession. The next step would be a systematic study with control group and follow-up procedures to see if these effects are lasting.

In addition, this approach has implications for other professions such as that of teaching. Learning is frequently a function of the interaction between the teacher and the student and the quality of their relationship. Teachers tend to be problem oriented, didactic, and like most people, tend to respond to problems with reassuring, probing or evaluative responses. Frequently, a student's feelings about his learning situation are not elicited and the student is simply labeled and misunderstood.

We frequently bemoan how little we know "with certainty" in Psychology but we have yet to apply out knowledge to other fields which could benefit from information which we take for granted.

TABLE 1

Response Type	Mean Pre	Mean Post	Standard Deviation Pre	Standard Deviation Post	*t* value p=<.001
Understanding	7.12	26.17	8.55	8.04	18.94
Evaluative	7.39	.74	5.14	1.22	-13.08
Reassuring	5.50	1.22	3.72	1.37	-12.61
Hostile	1.59	.36	1.66	.65	- 7.42
Probing	13.45	6.24	7.65	6.90	- 7.14

df - 101

Means, SD and *t* values for response categories on the Nurse-Patient Situation Test

TABLE 2

Response Type	Mean Pre	Mean Post	Standard Deviation Pre	Standard Deviation Post	t value	p
Understanding	6.35	22.76	6.86	15.43	3.84	< .005
Evaluative	12.31	4.92	9.39	4.45	2.78	< .01
Probing Facilitative	2.20	11.10	2.94	7.09	4.05	< .001
Probing Non-Facilitative	49.14	25.30	17.83	13.24	4.06	< .001
Probing Neutral	48.66	63.59	14.61	17.61	2.98	< .01
Hostile	.70	.13	1.08	.28	1.94	< .05
Reassuring	14.84	6.14	12.17	8.79	2.19	< .025
Overall Interview Rating	1.17	2.73	.32	1.18	4.83	< .001

* Non-significant for multiple t comparisons

Legend:

Mean, S.D. and t values for pre and post interviewing ratings.

References

1. Bennet, E.A. The Anxiety State. British Medical Journal 2 554-555, 1953.

2. Bernstein, L. Evaluating the Teaching of Physician-patient relationships. Psychotherapy and Psychosomatics, 21 214-219, 1972-73.

3. Bernstein, L. and Dana, R. Interviewing and the health professions. New York, Appleton Century-Crofts, 1970.

4. Bernstein, L., Brophy, M.L., McCarthy, M.J. and Roepe, R.L. Teaching nurse-patient relationships: an experimental study. Nursing Research 3 80-84, 1954.

5. Bernstein, Headlee, R., and Jackson, B. Changes in "acceptance of others" as a function of a course in the doctor-patient relationship. British Journal of Medical Education 4 65-66, 1970.

6. Carkhuff, R.R. Helping and Human relations: A primer for lay and professional helpers. Vols. 1 and 2. New York: Holt, Rinehart and Winston, 1969.

7. Cobb, B. Why do people detour to quacks? In Jaco, E.G., ed. Patients, physicians and illness. Glencoe, Ill., Free Press, 1958, pp. 283-287.

8. Ivey, A.E., Normington, C.J., Miller, C.D., Morrill, W.H. and Hasse, R.F. Microcounseling and attending behavior; an approach to prepracticum counselor training. Journal of Counseling Psychology, 1968, 15, 5.

9. Koos, E.L. "Metropolis" -- What city people think of their medical services. American Journal of Public Health, 45 1551-1557, 1955.

10. Menzel, H., Coleman, J., and Katz, E. Dimensions of being "modern" in medical practice. Journal of Cronic Disease, 9 20-40, 1959.

11. Porter, E.H., Jr. An introduction to therapeutic counseling. Boston; Houghton Mifflin, 1950.

12. Rogers, C.R., Client-centered therapy. Boston: Houghton Mifflin, 1951.

13. Winer, B.J., Statistical Principles in Experimental Design. New York: McGraw Hill, 1962.